DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 9, 2021

Administrator
Chris Jensen Health & Rehabilitation Center
2501 Rice Lake Road
Duluth, MN 55811

RE: CCN: 245366
Cycle Start Date: June 24, 2021

Dear Administrator:

On August 2, 2021, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
July 7, 2021

Administrator
Chris Jensen Health & Rehabilitation Center
2501 Rice Lake Road
Duluth, MN 55811

RE: CCN: 245366
Cycle Start Date: July 7, 2021

Dear Administrator:

On June 24, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag), i.e., the plan of correction should be directed to:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 24, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 24, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. BUILDING _____ B. WING _____	C 06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRIS JENSEN HEALTH & REHABILITATION CENTER	**2501 RICE LAKE ROAD DULUTH, MN 55811**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 6/24/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5366224C (MN74020) with a deficiency cited at F600. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600		7/28/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/16/2021

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F 600	Continued From page 1 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were free from abuse related to an allegation of resident to resident sexual abuse for 1 of 3 residents (R2) reviewed for abuse when R2 was touched inappropriately by R1. Findings include: R2's Admission Record printed 6/24/21, indicated R2's diagnoses included dementia. R2's quarterly Minimum Data Set (MDS) dated 5/27/21, indicated R2 was severely cognitively impaired. R2's care plan initiated 3/2/17, indicated R2 had a history of dementia. R2's care plan also included vulnerability related to auditory impairment and dementia initiated on 4/9/20. Interventions included annual vulnerable adult training for staff, observe for suspected abuse, remove resident from aggressor and relocate to a safe environment. R1's Admission Record printed on 6/24/21, indicated R1's diagnoses included dementia with behavioral disturbance. R1's admission MDS dated 6/2/21, indicated R1 was severely cognitively impaired. R1's MDS indicated R1 had physical, verbal, and other behaviors which did not include other residents.	F 600	F600 Freedom from Abuse Immediate Corrective Action •R1 was placed on 1:1, medications were adjusted for libido, and no longer resides at the facility. •R2 has been reviewed for any adverse effects of the incident and remains at baseline. Identification of other residents •Residents residing on the dementia unit. Corrective Action: Residents coded as having behaviors that affect others on the dementia unit have been assessed for therapeutic interventions that will aim to reduce behaviors that impact other residents. Education has been given to nursing staff on monitoring and supervision of resident with behaviors, implementation/effectiveness of interventions, and the importance of behavioral charting. Monitoring/Audits: Audits of staff redirection and supervision of wandering residents will be completed 5 days a week for 2 weeks then 3 days per week for 2 weeks and then weekly for 2 months. Compliance will be completed	

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F 600	Continued From page 2 R1's care plan initiated 6/4/21, indicated R1 had severely impaired cognition and behaviors included exit seeking, shouting, was in constant movement in wheelchair, and wasn't sleeping at night. R1's Bedside Kardex Report printed on 6/24/21, indicated R1 was on 15 minute safety checks. On 6/12/21, no checks were completed between 1:15 p.m. through 2:15 p.m. On 6/13/21, no checks were completed between 2:45 p.m. through midnight. On 6/14/21, no checks were completed between 12:15 a.m. through 6:15 a.m. On 6/15/21, no checks were completed between 4:45 p.m. through midnight On 6/18/21, no checks were completed between 6:45 p.m. through 9:45 p.m. On 6/19/21, no checks were completed between 7:30 p.m. through 7:45 p.m. On 6/21/21, no checks were completed between 6:45 a.m. through 10:00 a.m. On 6/23/21, no checks were completed between 12:15 a.m. through 2:15 a.m. and no again 5:45 p.m. through 10:15 p.m. A facility incident report submitted to the State Agency (SA) on 6/18/21, at 11:16 p.m. indicated R1 was found on 6/18/21, at 10:30 p.m. at R2's bedside with his hands on R2's groin area. The report indicated R2's incontinent brief was untouched, and groin area covered. Immediate steps were taken to remove R1 to a different room. The two residents were roommates. On 6/18/21, at 11:17 p.m. a progress note indicated a nursing assistant doing rounds found R1 parallel to R2's bed with his hand on R2's	F 600	by July 28th, 2021.	

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F 600	Continued From page 3	F 600		

groin. The note indicated families were called, as well as providers for both residents.

On 6/24/21, at 11:33 a.m. NA-B was interviewed. NA-B stated R1 was on 15 minute checks, she was aware that they were trying to keep him away from female residents. NA-B stated R1 would make sexual comments to female staff, "Do you want to stay, do you want to move to the bed?" NA -B described R1 as a "handful."

On 6/24/21, at 11:48 a.m. NA-C was interviewed. NA-C stated it was difficult to keep R1 away from the ladies. In addition, NA-C stated it could be difficult to do the 15 minute checks and complete resident toileting. NA-C stated they were trying to keep R1 in the dining room to keep eyes on him.

On 6/24/21, at 12:51 p.m. NA-E was interviewed. NA-E stated R1 would go into rooms looking for his wife and saying any female resident was his wife. NA-E readied R1 for bed on 6/18/21, R2 was already in bed. A little bit later she went to check on him and found him at R2's bedside. R2's incontinent brief was intact, but R1's hand was down R2's incontinent brief. NA-E removed R1 from the room, brought him to the desk and reported the incident to the nurse. NA-E stated R1 tried to touch her in the groin area, but she was able to get out of his reach and told him no. NA-E stated R1 kept trying to go into other residents room. NA-E stated R1 looked "scared" and uncomfortable. On 6/23/21, NA-E saw R1 trying to hug a female resident. NA-E stated the night shift staff consisted of one NA and one TMA, and they were not able to keep eyes on R1 throughout the shift.

On 6/24/21, at 1:15 p.m. registered nurse (RN)- A

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F 600	Continued From page 4	F 600		

was interviewed. RN-A stated the staffing for the night shift on the memory care unit was one NA and one TMA, for 28 residents. RN-A stated R1 had been on 15 minute checks for "weeks" and she had been thinking about lifting them. RN-A verified on the night shift when both staff are in a room doing repositioning or check and changes there would not be anyone to make sure R1 was not in another resident's room.

On 6/24/21, at 2:28 p.m. nurse practitioner (NP)-A was interviewed. NP-A stated he had put in a referral for behavioral health.

On 6/24/21, at 3:13 p.m. the director of nursing (DON) was interviewed. The DON verified R1 was on frequent checks after the first incident, but this did not prevent a second incident. The DON stated R1 was placed in a private room, and placed on 15 minute checks. The DON verified when both staff were in a resident room on the night shift, there would not be staff available to ensure R1 was not in another resident's room.

The policy Freedom from Abuse, Neglect, and Exploitation revision date 5/2020, directed staff to supervise residents to identify inappropriate behavior. The policy further directed staff to protect residents from harm during an investigation of abuse.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 7, 2021

Administrator
Chris Jensen Health & Rehabilitation Center
2501 Rice Lake Road
Duluth, MN 55811

Re: Event ID: 0M1511

Dear Administrator:

The above facility survey was completed on June 24, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
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	00598	A. BUILDING: _____ B. WING _____	C 06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRIS JENSEN HEALTH & REHABILITATION C	2501 RICE LAKE ROAD DULUTH, MN 55811

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/24/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5366224C (MN74020). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE	2 000		

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2 000	Continued From page 2 FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		